IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND
(Southern Division)

CONNECTICUT GENERAL LIFE INSURANCE COMPANY, *et al.*,	*	
	*	
Plaintiffs,	*	
v.	*	Civil Action No. DKC-14-2376
ADVANCED SURGERY CENTER OF BETHESDA, LLC, *et al.*,	*	
Defendants.	*	

* * * * * * * * *

MEMORANDUM IN SUPPORT
OF DEFENDANTS' MOTION TO DISMISS

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TABLE OF CONTENTS

INTRODUCTION 1

LEGAL STANDARD 3

ARGUMENT 3

I. Cigna's ERISA claim for alleged overpayments is prohibited because it seeks legal, not equitable, relief and because it breaches Cigna's duty of loyalty to its plan participants and beneficiaries. 3

A. Cigna's claim for alleged overpayments is prohibited because ERISA § 503(a)(2) permits plan fiduciaries to seek only equitable relief. 4

B. Cigna's lawsuit breaches Cigna's duty of loyalty to its participants and beneficiaries. 7

II. Cigna has failed to state a claim under RICO. 10

A. Cigna has failed to allege an actionable, ongoing, enterprise that is distinct from Defendants themselves and distinct from the alleged racketeering activity. 12

1. The alleged enterprises are not distinct from Defendants themselves. 12

2. Cigna does not allege that the alleged enterprises are distinct from the alleged racketeering activity. 16

B. Cigna has failed to allege an actionable pattern of racketeering activity 17

1. The ASCs were not obligated to disclose their billing practices to Cigna. 18

2. Cigna's allegations of racketeering activity by mail fraud and wire fraud are inconsistent with the documents attached to, and incorporated in its Complaint. Those documents reveal that the ASCs did not make any misrepresentations regarding their billing practices either affirmatively or through omission. 19

C. Cigna has not plausibly alleged that the damages it claims were proximately caused by any of the alleged misrepresentations by the ASCs. 20

III. Cigna's state-law claims are preempted by ERISA. 23

IV. Even if Cigna's state-law claims were not preempted by ERISA, they fail for other reasons. 24

V. Because there is no valid cause of action before this Court, Cigna's claim for a declaratory judgment must be dismissed. 26

CONCLUSION 26

Introduction

This case is about a medical billing dispute and nothing more. The root of this dispute is that Cigna does not want medical providers that are not part of its network to allow patients who have health insurance purchased from or administered by Cigna ("Cigna's insureds") to pay the same deductibles and co-payments the insureds would pay to an in-network provider. Because the defendant Ambulatory Surgical Centers (ASCs) have matched the in-network deductibles and co-payments charged to Cigna's insureds, Cigna seeks by this lawsuit to avoid paying *any amount* for services that the ASCs have provided to thousands of Cigna's insureds. In the counterclaim they have filed today, the ASCs have alleged and will prove that they are entitled to payment from Cigna for the medical services they provided to Cigna's insureds. But even if Cigna were correct that, by reducing the amount they charge patients for deductibles and co-payments, the ASCs somehow relieved Cigna of any obligation to pay for the treatment that its plan members received at the ASCs, this would still be nothing more than a medical billing dispute, not a RICO or fraud case.

Cigna's ERISA claim fails to the extent that it seeks monetary damages, as ERISA allows only equitable relief. Cigna also violates the duty of loyalty it owes to its insureds under ERISA by pursuing claims in this lawsuit that would, if successful, result in the insureds having to pay more for the services they received.

Cigna's RICO claim fails because Cigna has not alleged a "racketeering enterprise" (1) distinct from the ASCs and SurgCenter Development, Inc. ("SurgCenter") and (2) distinct from the alleged racketeering activity. Cigna alleges 20 separate conspiracies (associations in fact), each between one ASC and SurgCenter (the part-owner of all of the ASCs), to commit billing fraud. But such affiliated businesses cannot form a RICO enterprise for the purpose of carrying out one aspect of the ASC's business – its billing.

Cigna's RICO claims also fail because there was no racketeering activity – no fraud and no detrimental reliance. The only allegations of fraudulent statements – that the ASCs allegedly misrepresented to patients that they could use their in-network benefits and misrepresented to Cigna the ASCs' actual charges – are contradicted by the Complaint itself and by the exhibits Cigna attached to its Complaint. The exhibits demonstrate that each ASCs explicitly informed its patients that "[the ASC] is not a participating provider with your Insurance Plan," Compl. Ex. A, and explicitly informed Cigna that **"[t]he insured's portion of this bill has been reduced in amount so the patient's responsibility for the deductible and copay amount is billed at in-network rates.**" Compl. ¶ 92 and Ex. D (emphasis added). Because the documents themselves take precedence over Cigna's mischaracterization of them, the allegations of fraudulent statements fail. To the extent that Cigna seeks to rely on the ASCs' failure to reveal how they calculate their charges, that nondisclosure is not fraud, as the ASCs have no duty to reveal their billing formulas. Nor has Cigna adequately pled reliance on either the ASCs' charges or their failure to disclose their billing formulas. Cigna does not identify a single charge on which it allegedly relied for the amount it paid, nor explain how it relied on any of the ASCs' charges. The exhibits attached to Cigna's Complaint show no discernable relationship between the amount of the ASCs' charges and the amount Cigna paid for the billed services that would indicate any reliance on those charges.

Finally, Cigna's state-law fraud and misrepresentation claims are preempted by ERISA. Even if those claims were not preempted, they would fail for the same lack of misrepresentation and lack of reliance that doom the RICO claims.

Legal Standard

A motion to dismiss pursuant to Fed. R. Civ. P. 12(b)(6) tests the sufficiency of a complaint. *Chambers v. King Buick GMC, LLC*, --- F. Supp. 2d ---, No. DKC 13-2347, 2014 WL 4384316, at *4 (D. Md. Sept. 2, 2014). To satisfy the requirements of Fed. R. Civ. P. 8(a)(2), a plaintiff must make more than "a formulaic recitation of the elements of a cause of action" or "naked assertion[s] devoid of further factual enhancement." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (internal quotation marks omitted). The plaintiff must allege sufficient facts "to state a claim to relief that is plausible on its face." *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 570 (2007). "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Iqbal*, 556 U.S. at 678.

In addition, because Cigna has alleged fraud – both in the context of its RICO claims and its state law claims – it must comply with Fed. R. Civ. P. 9(b). That rule requires plaintiffs making an allegation of fraud to "state with particularity the circumstances constituting fraud." The heightened pleading standard of Rule 9 requires the plaintiff to specifically allege "the who, what, when, where, and how of the fraud and of the reliance thereon by the injured party." *In re Reciprocal of Ameria (ROA) Sales Practices Litig.*, MDL 1551, 2007 WL 2900287, at *11 (W.D. Tenn. Sept. 28, 2007). Judged by these standards, Plaintiffs' claims must be dismissed.

Argument

I. Cigna's ERISA claim for alleged overpayments is prohibited because it seeks legal, not equitable, relief and because it breaches Cigna's duty of loyalty to its plan participants and beneficiaries.

Count I of Plaintiffs' Complaint is styled "Claim for Overpayments Under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3)." Cigna seeks recovery of alleged "overpayments [that] were made in contravention of plan terms," Compl. ¶¶ 129 -137, and "a permanent injunction directing all of the ASCs to submit to Cigna only charges that the ASC actually charges the plan member as payment in full for the ASCs' services and not to submit charges which include amounts that the ASC does not actually require the member to pay . . . ." Compl. ¶ 138.

Cigna's ERISA claim fails to the extent that it seeks money damages. Its allegations also establish that, by pursuing this lawsuit, Cigna is violating the duty of loyalty it owes to its insureds, so the suit itself is barred by ERISA.

A. Cigna's claim for alleged overpayments is prohibited because ERISA § 503(a)(2) permits plan fiduciaries to seek only equitable relief.

ERISA authorizes plan fiduciaries like Cigna to bring a civil action "(A) to *enjoin* any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate *equitable* relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan." ERISA § 503(a)(2), 29 U.S.C. § 1132(a)(3) (emphasis added).

Cigna's claim for damages, characterized as a claim for repayment of alleged overpayments, is prohibited as a matter of law. As used in § 502(a)(3), "equitable relief," means only "those categories of relief that were typically available in equity . . . ." *Mertens v. Hewitt Assoc.*, 508 U.S. 248, 257-58 (1993) ("'Equitable' relief must mean *something* less than *all* relief," otherwise the term equitable would be rendered "meaningless." (emphasis in original)). The repayment of alleged overpayments that Cigna seeks is not equitable relief. Such repayments are *legal* damages and are therefore unrecoverable under ERISA.

Cigna's attempt to avoid this express limitation on relief available under ERISA by characterizing its claim as one for "reimbursement" rather than damages is inadequate. The Supreme Court has held that ERISA's limited, equitable remedies do not allow insurers to seek reimbursement of funds when those funds are not separately held by the defendant. *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 213-14 (2002). The Court noted that "a plaintiff could seek restitution in equity" only where money belonging to the plaintiff "could clearly be traced to particular funds or property in the defendant's possession." *Id.* at 213. It explained that, as a general matter, an action in equity "must seek not to impose personal liability on the defendant" but simply looks to recover "particular funds or property in the defendant's possession." *Id.* at 214. In contrast, where "the plaintiff '*could not* assert title or right to possession of particular property, but in which nevertheless he might be able to show just grounds for recovering money to pay some benefit the defendant had received from him,' the plaintiff had a right to *restitution at law* through an action derived from the common-law writ of assumpsit." *Id.* at 213 (quoting 1 Dobbs § 4.2(1) at 571) (emphasis in *Knudson*). In *Knudson*, the plan's sponsor and its administering insurance company sought restitution pursuant to a policy provision allowing recovery of benefits paid by the plan when the beneficiary also recovered damages from a third party. The Supreme Court pointed out that the plaintiffs did not seek "particular funds" that belonged to the insurance plan but, rather, contended that they were "contractually entitled to *some* funds for benefits they conferred." *Id.* at 214. Therefore, the restitution sought by the Knudson plaintiffs was legal, not equitable, and so was not available under ERISA. *Id.*

In contrast, in *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006), the Court held that ERISA allows an insurer's claim for equitable restitution to recover funds to which it is entitled when those funds are separately held in a discrete account or investment. In that case, the relief sought by the insurer was equitable because it did not seek recovery from the beneficiaries' "assets generally," but "sought specifically identifiable funds that were within the possession and control of the [the defendants] – that portion of the tort settlement due [the plaintiff-insurer] under the terms of the ERISA plan, set aside and preserved [in the defendants'] investment accounts." *Id.* at 362-63 (internal quotation marks omitted).

Under *Knudson* and *Sereboff*, Cigna's claim for the alleged overpayments must be dismissed. Nowhere in its Complaint does Cigna allege that any of the funds it seeks are "specifically identifiable" and separate and apart from the ASCs' general assets. Cigna seeks only the "return of any [and] all monies paid to the ASCs on claims for reimbursement submitted by the ASCs." Compl. at 54, Prayer for Relief ¶ b. Because it does not, and cannot, seek identifiable assets from a "particular fund," Cigna's claim sounds in law rather than equity. *See Curran v. Camden Nat'l Corp.*, 477 F. Supp. 2d 247, 257 (D. Me. 2007).

> [W]here the property sought to be recovered or its proceeds have been dissipated so that no product remains, the plaintiff's claim is only that of a general creditor and the plaintiff cannot enforce a constructive trust or an equitable lien upon other property of the defendant.

Knudson, 534 U.S. at 213-14 (quoting Restatement of Restitution § 214, Cmt. a.) (internal quotation marks and brackets omitted)).

Moreover, Cigna has not alleged the existence of any agreement, in the plan documents or elsewhere, between Cigna and its plan participants and beneficiaries that either requires the participants and beneficiaries to reimburse Cigna for a portion of the benefits they have received from it (similar to the provision in *Sereboff*, 547 U.S. at 359), or provides it with a lien on any portion of the benefits it has paid to the ASCs (similar to the provision that existed in *Knudson*, 534 U.S. at 207). Because Cigna has not alleged that it is entitled to particular or specifically identified funds in the ASCs' possession, its "claim for [alleged] overpayments" seeks legal, not equitable, restitution and must be dismissed.

Cigna's alternative claim for "a declaration that it may offset from future claim payments to the ASCs in the amount of these overpayments," Compl. ¶ 137, fares no better. Cigna essentially seeks this Court's permission to withhold benefits from unrelated plan participants and beneficiaries in the future because of the ASCs' allegedly improper conduct in the past. Such offset or withholding would cause Cigna to breach the fiduciary duty it owes to those members to take action with respect to its plans "solely in the interest of the participants and beneficiaries" (*see* Section I.B, below), and would leave those members responsible for bills for which they have paid for insurance (or, if somehow no one were responsible for those bills, would result in those members being denied the medical services they seek).

B. Cigna's lawsuit breaches Cigna's duty of loyalty to its participants and beneficiaries.

Count I reveals Cigna's confusion about its role as an ERISA plan fiduciary. By seeking to force its insureds to pay more for medical services to which they are otherwise entitled, Cigna's lawsuit violates its duty of loyalty to its plan participants and beneficiaries.

As this Court has explained, to succeed on a claim for breach of fiduciary duty one must prove "(1) each Defendant is a fiduciary; (2) each Defendant breached a duty; (3) that the breach has caused damage; and (4) the amount of damages that are attributable to the fiduciary breaches." *Boyd v. Coventry Health Care, Inc.*, 299 F.R.D. 451, 466 (D. Md. 2014). Each of these elements of *Cigna's liability* is stated in Cigna's own allegations.

Cigna acknowledges that it "is a fiduciary […] of the plans that it administers." Compl. ¶ 128. ERISA imposes explicit duties on fiduciaries of covered insurance plans. Those duties include the requirement that fiduciaries act "with respect to the plan *solely in the interest of the participants and beneficiaries*" and "for the *exclusive purpose* of (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan." 29 U.S.C. § 1104(a)(1) (emphasis added). The breadth of this "duty of loyalty" to plan participants and beneficiaries is "strict" and "unyielding." *Mass. Mut. Life Ins. Co. v. Russell,* 473 U.S. 134, 152-53 (1985) (Brennan, J., concurring) ("Congress intended by § 404(a) to incorporate the fiduciary standards of trust law into ERISA, and it is black-letter trust law that fiduciaries owe strict duties running directly to beneficiaries in the administration and payment of trust benefits."). *Griggs v. E.I. DuPont de Nemours & Co.*, 237 F.3d 371, 380 (4th Cir. 2001) ("[A] fiduciary has an unyielding duty of loyalty to the beneficiary."). Cigna violates that duty here by seeking to retroactively deny coverage (for claims it has already paid) or refusing to pay for its insureds' out-of-network care without justification.

Cigna's allegations reveal that it has little regard for the interests of its plan participants and beneficiaries. Its primary interest is its own financial well-being (in the case of its "fully-insured plans," Compl. ¶ 44), or that of its plan sponsors (in the case of its "Administrative Services Only" plans, Compl. ¶ 42).[1] This Court has held that "[a] claim for breach of fiduciary duty may be alleged by showing that the administrator 'acted with an eye only toward the interests of [the plan sponsor], and not toward [plan participants and beneficiaries].'" *Cuthie v. Fleet Reserve Ass'n*, 743 F. Supp. 2d 486, 497 (D. Md. 2010) (quoting *Corrado v. Life Investors Owners Participation Trust and Plan*, No. DKC 2008-0015, 2009 WL 3062320, at *7–8 (D. Md. Sept. 21, 2009)). By seeking to deny coverage to its insureds for the services provided by the ASCs, Cigna is doing precisely that. Cigna acknowledges that it is seeking to protect the interest of the employers who fund the plans it administrators (not the participants and beneficiaries),

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[1] Cigna makes no attempt to hide its conflict of interest as the insurer with the responsibility to pay claims and as the administrator of the plan with discretion to determine entitlement to benefits. *See Carden v. Aetna Life Ins. Co.*, 559 F.3d 256, 260 (4th Cir. 2009) (finding a conflict in similar circumstances). Cigna acknowledges that it funds its own fully insured plans, Compl. ¶ 44, and "serves as a claims administrator for each plan and exercises discretionary authority over the administration of the plan." Compl. ¶ 46.

Compl. ¶ 43, and that it is seeking recovery on behalf of the plans (not the participants and beneficiaries). Compl. ¶¶ 45, 137 ("Cigna seeks recovery of these overpayments on behalf of the plans.").[2] Cigna is violating its duty of loyalty because the interests of "the plans" and their sponsors, on whose behalf Cigna is acting, are in direct conflict with those of Cigna's insureds, who properly elected to seek their medical care at an out-of-network facility. *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 112 (2008) ("[T]he employer has an interest … conflicting with that of the beneficiaries …." (internal quotation marks omitted)).

By filing this lawsuit, Cigna not only fails to take action in the interest of the only individuals ERISA requires it to protect – its plan participants and beneficiaries – it is actively working against them. Should Cigna prevail in this lawsuit, the third and fourth elements of a claim for breach of fiduciary duty will be met. Cigna's recovery of the alleged overpayments, non-payment of contested claims, or both would cause the ASCs to seek to collect the full cost of the services rendered from Cigna's plan participants and beneficiaries, the only other parties liable for payment of the charges. *See* Compl. Ex. E. Every dollar that Cigna recovers from the ASCs or does not pay to the ASCs is a dollar that Cigna's insureds will have to pay.

Because Cigna's allegations show that it, not the defendant ASCs, is the party violating ERISA, Count I should be dismissed (as should the entire complaint to the extent it applies to claims under ERISA-governed plans).

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[2] To the extent that Cigna claims its plan documents permit it to pursue its claims here, it is wrong. The Supreme Court has held that "trust documents cannot excuse trustees from their duties under ERISA." *Cent. States, Se. & Sw. Areas Pension Fund v. Cent. Transp., Inc.*, 472 U.S. 559, 568-69 (1985); *see also Boyd v. Metro. Life Ins. Co.*, 636 F.3d 138, 140 (4th Cir. 2011) ("[P]lan administrators must act 'in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with' the other provisions of ERISA.").

II. Cigna has failed to state a claim under RICO.

In Counts II.A through T of its Complaint, Cigna seeks damages under the Racketeer Influenced and Corrupt Organizations Act.[3] It alleges that each of the ASCs conspired with SurgCenter, their common part-owner, Compl. ¶ 143, and claims that in each of 20 separate conspiracies, SurgCenter and one of the ASCs – and only those entities – formed a "two-party association-in-fact enterprise[]" to carry out the allegedly fraudulent billing scheme. Compl. ¶ 140. Cigna, however, does not allege facts sufficient to establish that the alleged enterprises are distinct from (1) the affiliated defendants that make them up, or (2) the pattern of racketeering activity that the enterprises are alleged to have carried out.

Cigna alleges that the purported enterprises engaged in mail fraud and wire fraud by submitting claims to Cigna. But many of those allegations are contradicted elsewhere in the Complaint or by documents attached to the Complaint, so they are not entitled to the presumption of truth normally afforded on a motion to dismiss.[4] For example, even though

[3] A civil RICO claim under 18 U.S.C. § 1962(c) requires proof of four elements: (1) conduct (2) of an enterprise (3) through a pattern (4) of racketeering activity. *Sedima S.P.R.L. v. Imrex Co., Inc.*, 473 U.S. 479, 496 (1985). Plaintiffs are also required to allege and prove that the alleged racketeering activity was the proximate cause of their injury. *Hemi Group, LLC v. City of New York*, 559 U.S. 1, 9 (2010); *Holmes v. Sec. Investor Prot. Corp.*, 503 U.S. 258, 268 (1992)).

[4] "Where plaintiff's own pleadings are internally inconsistent, a court is neither obligated to reconcile nor accept the contradictory allegations in the pleadings as true in deciding a motion to dismiss." *U.S. Bank Nat. Ass'n v. Bank of Am., N.A.*, No. 12 CIV. 4873 CM, 2012 WL 6136017, at *7 (S.D.N.Y. Dec. 11, 2012) (quoting *Nationwide Mut. Ins. Co. v. Morning Sun Bus. Co.*, No. 10 Civ. 1777, 2011 WL 381612, at *6 (E.D.N.Y. Feb. 2, 2011)). Moreover, "[a] copy of a written instrument that is an exhibit to a pleading is a part of the pleading for all purposes." Fed. R. Civ. P. 10(c). When the contents of a document attached to a complaint contradict the plaintiff's assertions, the contents of the document "prevail over the conflicting characterizations by a plaintiff," and dismissal is appropriate if the document's contents reveal that recovery is unavailable. *Proctor v. Metro. Money Store Corp.*, 579 F. Supp. 2d 724, 735 (D. Md. 2008); *see also Associated Builders, Inc. v. Alabama Power Co.*, 505 F.2d 97, 100 (5th Cir. 1974) ("Conclusory allegations and unwarranted deductions of fact are not admitted as true, … especially when such conclusions are contradicted by facts disclosed by a document appended to

Cigna claims that the ASCs affirmatively misrepresented their billing practices, the sample claim form Cigna attaches to the Complaint states that "[t]he insured's portion of this bill has been reduced in amount so that the patient's responsibility for the deductible and copay amount is billed at in network rates." Compl. Ex. D; Compl. ¶ 92. Likewise, Cigna's claim that it relied on the amounts reflected on the claim forms submitted by the ASCs (though Cigna does not say how it relied on them) is belied by (1) its admission that its payments are limited to a "Maximum Reimbursable Charge" in an amount set by the plan, Compl. ¶ 73, and (2) the spreadsheets attached to its Complaint, which list the amounts of claims submitted by the ASCs and the amount that Cigna paid on each such claim. Compl. Exs. F through X. Those spreadsheets reveal that Cigna paid nothing for many of the claims at issue and paid less than half of the claim submitted for the vast majority of the claims. More importantly, there is no discernable relationship between the amount of the claims submitted by the ASC and the amount Cigna paid.

The Fourth Circuit has cautioned against plaintiffs attempting to use RICO as a means of vindicating conduct that, if proven, would amount to nothing more than "ordinary commercial fraud." *Menasco, Inc. v. Wasserman,* 886 F.2d 681, 685 (4th Cir. 1989); *see also Al-Abood v. El-Shmari*, 217 F.3d 225, 238 (4th Cir. 2000) (noting that caution is particularly important when the RICO claim is based on predicate acts of mail fraud and wire fraud, so as to "preserve a distinction between ordinary or garden-variety fraud claims better prosecuted under state law and cases involving a more serious scope of activity."). It has similarly cautioned against attempts to transform contract disputes into RICO claims. *Flip Mortg. Corp. v. McElhone,* 841 F.2d 531,

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the complaint. If the appended document, to be treated as part of the complaint for all purposes under Rule 10(c) … reveals facts which foreclose recovery as a matter of law, dismissal is appropriate."); 5 Wright & Miller, Fed. Prac. & Proc. § 1327 ("by attaching an exhibit, the pleader often may foreclose recovery on a theory of relief that he claims is available to him since the document itself may reveal the existence of an insurmountable defense").

538 (4th Cir. 1988) ("[T]his circuit will not lightly permit ordinary business contract or fraud disputes to be transformed into federal RICO claims."). This is because "[a] civil RICO action does not cover all instances of wrongdoing. Rather, it is a unique cause of action that is concerned with eradicating organized, long-term, habitual criminal activity." *Yesko v. Fell*, No. ELH-13-3927, 2014 WL 4406849 (D. Md. Sept. 5, 2014) (quoting *U.S. Airline Pilots Ass'n v. Awappa, LLC*, 615 F.3d 312, 317 (4th Cir.2010)) (internal quotation marks omitted). This Court has heeded these cautions by dismissing such overreaching claims.[5] RICO is reserved for "ongoing unlawful activities whose scope and persistence pose a special threat to social well-being." *Grant v. Shapiro & Burson, LLP*, 871 F. Supp. 2d 462, 474 (D. Md. 2012) (quoting *GE Inv. Private Placement Partners II v. Parker*, 247 F.3d 543, 549 (4th Cir.2001) (internal citations omitted)). Because, at most, Cigna's allegations describe a dispute over the legitimacy of the ASCs' billing practices, not habitual criminal activities that pose a "special threat to social well-being," Counts II.A through II.T should be dismissed.

A. Cigna has failed to allege an actionable, ongoing, enterprise that is distinct from Defendants themselves and distinct from the alleged racketeering activity.

RICO requires plaintiffs to allege a racketeering enterprise that is distinct from the collaborators themselves and the activity of which is distinct from the alleged racketeering activity. Cigna's RICO claim fails both requirements.

1. The alleged enterprises are not distinct from Defendants themselves.

Section 1962(c) speaks of "distinct entities: (1) a 'person'; and (2) an 'enterprise' that is not simply the same 'person' referred to by a different name." *Cedric Kushner Promotions, Ltd.*

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[5] *See, e.g., Grant v. Shapiro & Burson, LLP*, 871 F. Supp. 2d 462, 474-75 (D. Md. 2012); *Orteck Int'l Inc. v. TransPacific Tire & Wheel, Inc.*, No. DKC 2005-2882, 2006 WL 2572474 *16-19 (D. Md. Sept. 5, 2006); *Lowry's Reports, Inc. v. Legg Mason, Inc.*, 186 F. Supp. 2d 592, 593-94 (D. Md. 2002); *Maryland-National Capital Park and Planning Comm'n. v. Boyle*, 203 F. Supp. 2d 468, 476-78 (D. Md. 2002).

v. King, 533 U.S. 158, 161 (2001). Thus, Cigna must allege "that the RICO 'enterprise' is distinct from the defendant 'person' alleged to have violated RICO." *Mitchell Tracey*, 935 F. Supp. 2d at 842. It has failed to do so.

Recognizing that one cannot associate with oneself[6] and, thus, that it could not allege that each ASC is an enterprise with which SurgCenter is associated while still naming the ASCs as defendants or vice versa, Cigna alleges separate associations-in-fact, each comprised of SurgCenter and one of the ASCs. Compl. ¶ 140. But that allegation does not change the fact that, as alleged by Cigna's complaint, all of the allegedly fraudulent activities are committed by the ASCs with respect to the billing aspects of their surgery centers, *not* the alleged enterprises. This Court has previously seen through such attempts to evade the distinctiveness requirement by alleging enterprises that are made up entirely of the defendants that are affiliated with one another, and it should do so again here.

For example, in *Gondel v. PMIG 1020, LLC*, the plaintiffs alleged that three corporations associated to create an enterprise that made fraudulent representations to the plaintiffs regarding the profitability of a business they sold to the plaintiffs. No. CCB-08-1768, 2009 WL 248681, *4 (D. Md. Jan. 22, 2009). This Court recognized that "[b]y naming [the three corporations] as the defendants, and alleging only that these corporate defendants – through themselves and their agents – engaged in racketeering activity, plaintiffs make precisely the type of RICO allegation that fails to differentiate between 'person' and 'enterprise.'" *Id.* at *4. It dismissed the plaintiffs' claim for failing "to make out a prima facie case under § 1962(c)." *Id.*

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[6] *See United States v. Computer Sci. Corp.*, 689 F.2d 1181, 1190 (4th Cir. 1982) ("[W]e would not take seriously, in the absence, at least, of very explicit statutory language, an assertion that a defendant could conspire with his right arm, which held, aimed and fired the fatal weapon."); *Haroco v. Am. Nat'l Bank*, 747 F.2d 384, 399-400 (7th Cir. 1984) (In § 1962(c) "[t]he use of the terms 'employed by' and 'associated with' appears to contemplate a person distinct from enterprise.") *United States v. Benny*, 786 F.2d 1410, 1415 (9th Cir. 1986) (quoting *Haroco*); *Yellow Bus Lines, Inc. v. Local Union 639*, 883 F.2d 132, 139 (D.C. Cir. 1989) ("Logic alone dictates that one entity may not serve as the enterprise and the person associated with it because ... you cannot associate with yourself." (internal quotation marks and citations omitted)).

Similarly, in *Bailey v. Atlantic Auto. Corp.*, the plaintiffs alleged an association-in-fact enterprise comprised of a corporation and 20 of its subsidiaries. 992 F. Supp. 2d 560 (D. Md. 2014) (Garbis, J.). The plaintiffs acknowledged that that the corporate owner was involved in the management of its subsidiaries, *id.*, but nonetheless claimed that, because each of the members of the supposed enterprise were separately incorporated and had their own business locations and employees, the Court could find that they were distinct from the supposed enterprise. *Id.* at 583. This Court rejected the plaintiffs' position and granted the defendants' motion to dismiss, reasoning that "just as adequate distinctiveness may be missing between a parent-person and a wholly owned subsidiary-enterprise (or vice versa), it may also be lacking where the parent and its wholly owned subsidiaries are both the 'alleged person' and the sole members of the association-in-fact enterprise." *Id.* at 582.

Just last month, this Court reaffirmed the propriety of *Bailey* but reached a different conclusion on different facts, providing a useful contrast to the facts presented here. *Chambers v. King Buick GMC, LLC*, --- F. Supp. 2d ---, No. DKC 13-2347, 2014 WL 4384316 *7-9 (D. Md. Sept. 2, 2014). It recognized that "'an organization cannot join with its own members to undertake regular corporate activity and thereby become an enterprise distinct from itself,'" but determined that that was not the situation there. *Id.* at *9 (quoting *Begala v. PNC Bank, Ohio, N.A.*, 214 F.3d 776, 781 (6th Cir. 2000)). Rather, the plaintiff alleged an association-in-fact enterprise made up of six *independent* auto dealerships. *Id.* at *2. RICO's distinctiveness requirement was satisfied by that independence, *id.* at *9 – an independence absent here, as

Cigna has alleged that SurgCenter is a 35% owner of each ASC, provides management services to each ASC, and directed the alleged scheme. Compl. ¶¶ 73, 74, 79.

Plaintiffs' allegations in this case are indistinguishable from those in *Gondel* and *Bailey*. As in *Gondel*, Cigna alleges that the only Defendants liable for each purported enterprise are the same entities that make up the enterprise and engaged in the alleged racketeering activity. *E.g.*, Compl. ¶ 158 ("SurgCenter and Advanced Surgery Center of Bethesda entered into a two-party enterprise … to engage in the actions described in Paragraphs 70-96, 140-56"); Compl. ¶ 161 ("SurgCenter and Bethesda Chevy Chase Surgery Center entered into a two-party enterprise … to engage in the actions described in Paragraphs 70-96, 140-56"). As in *Bailey*, the management of the Defendants overlaps, with one Defendant involved in the management of the other. Cigna recognizes that SurgCenter maintains a sizeable ownership interest in each of the ASCs, Compl. ¶ 74, and alleges that SurgCenter provides management services for the ASCs, including directing all aspects of the alleged "pricing scheme." Compl. ¶¶ 73, 79. Thus, according to Cigna, each of the alleged enterprises consists of SurgCenter, on the one hand, and one of its affiliated ASCs on the other. This is insufficient to state a "plausible" RICO claim. *Apache Tribe of Oklahoma v. Brown*, 966 F. Supp. 2d 1188, 1194 (W.D. Okla. 2013) (no plausible RICO claim where the enterprise identified "'is simply the group of individual defendants accused of engaging in racketeering'"(quoting *Switzer v. Coan*, 261 F.3d 985, 992 (10th Cir. 2001)); *see also Myers v. Lee*, No. 1:10CV131 AJTJFA, 2010 WL 3745632 (E.D. Va. Sept. 21, 2010) (granting motion to dismiss where "[t]here is a complete overlap between the defendants, their alleged agents, and the enterprise," and "[t]he sum total of the allegations set forth in the Amended Complaint does no more than allege that the defendants associated with themselves for the purpose of conducting defendant Lee's and the other defendants' business affairs through entities created for that purpose.").

2. Cigna does not allege that the alleged enterprises are distinct from the alleged racketeering activity.

"[A]n enterprise "must be more than a group of people who get together to commit a pattern of racketeering activity." *Crissen v. Gupta*, 994 F. Supp. 2d 937, 947 (S.D. Ind. 2014) (quoting *United States v. Neapolitan*, 791 F.2d 489, 499–500 (7th Cir. 1986) (internal quotations omitted)); *see also United States v. Tillett*, 763 F.2d 628, 631 (4th Cir. 1985) (RICO requires proof "that the association exists separate and apart from the pattern of racketeering activity in which it engages."). Because an "enterprise" and a "pattern of racketeering activity" are separate elements that must be proved to establish liability under RICO, courts must "determine if the enterprise would still exist were the predicate acts removed from the equation." *Handeen v. Lemaire*, 112 F.3d 1339, 1352 (8th Cir. 1997).

The alleged RICO enterprises here would not exist if the predicate acts were removed. The only conduct Cigna attributes to the alleged enterprises is wholly co-extensive with the alleged racketeering activities. Courts have dismissed RICO claims under just such circumstances. For example, in *Tri-Cnty. Elec. Co. v. Dean*, the court dismissed the plaintiffs' RICO claims that, like Cigna's claims here, "define[d] the[] associated-in-fact enterprises as the racketeering activity." No. 92-0085-E, 1994 WL 653489 *3 (N.D.W. Va. Sept. 23, 1994). Like the plaintiffs in *Dean*, Cigna has incorporated the same allegations used to support its claim of racketeering activity into its definitions of the alleged enterprises. *Id.*; Compl. ¶ 142 (describing "The Pattern of Racketeering Activity" and incorporating Compl. ¶¶ 70-96); Compl. ¶ 140 (describing "The Enterprises" and incorporating Compl. ¶¶ 70-96). Cigna does not allege that the "enterprises" also engaged in legitimate business (as explained above, if Cigna made such an allegation, the legitimate business would be the ASC, which, as one of the defendants, cannot also be the RICO enterprise). It has, therefore, failed to allege enterprises that are distinct from the alleged pattern of racketeering activity, so Cigna's RICO claims should be dismissed.

B. Cigna has failed to allege an actionable pattern of racketeering activity.

RICO defines "racketeering activity" as, *inter alia*, "any act which is indictable under … title 18, United States Code: … section 1341 (relating to mail fraud), section 1343 (relating to wire fraud) …." Plaintiffs allege that Defendants' "racketeering activity" consisted of violations of these sections by virtue of their submission of "fraudulent claim forms to Cigna" on numerous occasions. Compl. ¶¶ 148-150.

"The elements of mail fraud are (1) a scheme disclosing an intent to defraud, and (2) the use of the mails in furtherance of the scheme." *Chisolm v. TranSouth Fin. Corp.*, 95 F.3d 331, 336 (4th Cir. 1996); *see also Kerby*, 992 F. Supp. 787, 798 (D. Md. 1998) ("[w]ire fraud is similar [to mail fraud], except that 'wire, radio, or television,' rather than the mails, provides the means to further the fraud."). The scheme to defraud must involve material misrepresentations, *Neder v. United States*, 527 U.S.1, 25 (1999), and the perpetrator of the fraud must have acted with "the specific intent to deprive one of something of value through a misrepresentation." *United States v. Wynn*, 684 F.3d 473, 478 (4th Cir. 2012). Cigna's allegations of racketeering activity are legally insufficient because (1) the ASCs were not obligated to disclose their billing practices to Cigna, and (2) Cigna's allegation that Defendants made material misrepresentations to it regarding Defendants' billing practices, either affirmatively or by omission, are contradicted by the documents attached to the Complaint and by Cigna's acknowledgement that the ASCs truthfully explained that their patients' cost-sharing obligations had been reduced.

1. The ASCs were not obligated to disclose their billing practices to Cigna.

Cigna implicitly asserts that the ASCs were obligated to disclose their pricing and billing practices to Cigna and claims (explicitly) that failing to do so was tantamount to an affirmative misrepresentation actionable as fraud. Compl. ¶¶ 91-92. Mail fraud and wire fraud charges may be premised on a party's failure to disclose material facts with an intent to deceive. *United States v. Colton*, 231 F. 3d 890, 898-900 (4th Cir. 2000). A party's obligation to disclose facts may arise from common law, statute, or a fiduciary relationship. *Id.* at 900. It may also arise from "simple 'good faith' [which] imposes an obligation not to purposefully conceal material facts with an intent to deceive." *Id.* But here, no obligation required the ASCs to disclose their pricing and billing practices to Plaintiffs.

In *Langford v. Rite Aid of Alabama, Inc.*, the plaintiffs sued a pharmacy chain under RICO alleging that the pharmacy committed wire fraud and mail fraud by failing to disclose its differential pricing policy. 231 F.3d 1308 (11th Cir. 2000). Pursuant to the policy, customers with insurance were charged less for their prescriptions than those without insurance. *Id.* at 1310. In affirming the district court's dismissal of the complaint, the Eleventh Circuit explained that "[a]s a general matter of federal law, retailers are under no obligation to disclose their pricing structure to consumers," and "[d]ifferential pricing alone is not a fraudulent practice. *Id.* at 1313-14; *Katzman v. Victoria's Secret Catalogue*, 167 F.R.D. 649, 656 (S.D.N.Y. 1996) (no duty to disclose "promotional practices"), *aff'd*, 113 F.3d 1229 (2d Cir. 1997). Likewise, although Cigna alleges that the ASCs "never disclosed the true nature" of their pricing scheme, Cigna fails to allege any basis for imposing an obligation on the ASCs to disclose their pricing and billing practices. Because the ASCs here were not obligated to disclose those practices, they cannot have committed fraud by omission.

2. Cigna's allegations of racketeering activity by mail fraud and wire fraud are inconsistent with the documents attached to, and incorporated in its Complaint. Those documents reveal that the ASCs did not make any misrepresentations regarding their billing practices either affirmatively or through omission.

Cigna alleges two types of misrepresentations by the ASCs. First, it alleges that "each ASC knowingly misrepresented to patients that the patients could use their 'in-network' benefits at the ASCs even though the ASCs were out-of-network facilities." Compl. ¶ 89; *see also* Compl. ¶ 85. In addition, it alleges that "each ASC misrepresented its actual charges for the services rendered to Cigna affirmatively and through omission." Compl. ¶ 87. In both instances, Cigna's allegations are directly contradicted by documents it has attached to the Complaint and should not be credited by this Court. *See supra* note 4.

Here, despite Cigna's allegation that the ASCs misrepresented to their patients that they could use their in-network benefits at the ASCs, Exhibit A to the Complaint reveals that they did no such thing. That letter from Hagerstown Surgery Center, LLC explicitly states that "Hagerstown Surgery Center is not a participating provider with your Insurance Plan." Rather than representing to patients that they could use Cigna's in-network benefits at Hagerstown Surgery Center, the surgery center simply *explained its own billing policy*, stating that "[i]t is the policy of Hagerstown Surgery Center to extend 'in-network benefits' to all of our patients."

When compared to Exhibit D, Cigna's allegation that the ASCs misrepresented the charges for the treatment provided is similarly flawed. As noted above, Cigna acknowledges that the claims forms it received from the ASCs explicitly state that "[t]he insured's portion of this bill has been reduced in amount so the patient's responsibility for the deductible and copay is billed at in network rates." Compl. ¶ 92. Thus, the ASCs disclosed to Cigna that the bill to its insureds was being reduced so that the patient's deductible and copay would match their in-network deductible and copay.

Cigna grasps at straws, claiming that it was misled because the words "this bill" allegedly suggested that the amount reflected on the claim form was the same amount the patient was billed. Compl. ¶ 93. In the context of the other language of the disclosure – "the patient's responsibility for the deductible and copay is billed at in network rates" – Cigna's assertion is implausible. Cigna could readily see that the amount submitted on the claims form was not the contract rate Cigna has agreed to pay its network providers and thus could not have been the amount used to calculate the patient's contribution. Cigna also does not deny that it was aware of the common practice of ASCs reducing their patients' deductibles and co-pays to match their in-network levels. *See, e.g.,* Charles C. Dunham, *Out-of-Network Referrals and Waiver of Patient Copayments and Deductibles: The Battle Between Payors and Providers Endures and Intensifies*, The Health Lawyer, June 2013 at 18-23.

C. Cigna has not plausibly alleged that the damages it claims were proximately caused by any of the alleged misrepresentations by the ASCs.

Cigna is required to plead and prove that the alleged pattern of racketeering activity was the proximate cause of its damages. *Hemi Group, LLC v. New York,* 559 U.S. 1, 9 (2010); *Holmes v. Securities Investor Prot. Corp.*, 503 U.S. 258, 268 (1992); *see also Chambers*, 2014 WL 4384316, at *5. In the context of RICO, proximate cause "should be evaluated in light of its common-law foundations; proximate cause thus requires 'some direct relation between the injury asserted and the injurious conduct alleged.'" *Hemi Group,* 559 U.S. at 9 (quoting *Holmes*, 503 U.S. at 268). When a RICO claim is predicated on allegations of mail fraud and wire fraud, showing reliance on the alleged fraudulent representations establishes the required "direct relation" between the plaintiff's alleged injury and the asserted misconduct. *Chisolm v. TranSouth Fin. Corp.*, 95 F.3d 331, 337 (4th Cir. 1996). Here, Cigna has not adequately pled that its injuries were proximately caused by the ASCs alleged misrepresentations. Its allegations regarding reliance either (1) are entirely absent, (2) fail to meet the heightened pleading requirements of Rule 9, or (3) are implausible.

"Reasonable, detrimental reliance upon a misrepresentation is an essential element of a cause of action for fraud … and such reliance must be pleaded with particularity." *Learning Works, Inc. v. The Learning Annex, Inc.*, 830 F.2d 541, 546 (4th Cir. 1987)). Rule 9 requires that a complaint alleging fraud to provide details regarding "the who, what, when, where, and how" of the fraud, including its alleged reliance. *Mizell v. Sara Lee Corp.*, No. 2:05CV129, 2005 WL 1668056, at *6 (E.D. Va. June 9, 2005) (dismissing fraud claim) *aff'd*, 158 F. App'x 424 (4th Cir. 2005); *In re Reciprocal of Ameria (ROA) Sales Practices Litig.*, MDL 1551, 2007 WL 2900287, at *11 (W.D. Tenn. Sept. 28, 2007) (dismissing fraud claim where plaintiff failed to "set forth with particularity facts showing specifically the who, what, when, where, and how of the fraud and of the reliance thereon by the injured party.").

As noted above, Cigna has alleged that the ASCs made misrepresentations both to it and to the ASCs' patients. With regard to the latter, Cigna alleges that the ASCs misrepresented "to patients that the patients could use their 'in-network' benefits at the ASCs even though the ASCs were out-of-network facilities." Compl. ¶ 89. But (in addition to the fact that, as explained above, the ASCs explicitly disclaimed being in-network providers, and only, truthfully, told the patients that the ASCs would bill them for their deductible and copayments at their in-network rates), nowhere does Cigna allege that the patients relied on the alleged misrepresentation that they could use their "in-network" benefits at the ASCs, or how they so relied. Thus, it has not plausibly alleged that those misrepresentations were the proximate cause of its claimed damages.

Cigna's allegations of its own reliance do not meet Rule 9's pleading standard. Cigna simply states that it "relied on the amount that the ASCs billed to Cigna in their claim forms when processing and paying the ASCs' claims." Compl. ¶ 87.[7] Cigna's generic allegation that it "relied on the amount that the ASC's billed," Compl. ¶ 87, "falls well short of the particularity that is required for fraud claims." *Mizell*, 2005 WL 1668056, at *6. Nowhere does Cigna describe *how* it allegedly relied on the billed amount, a "how" that is particularly relevant given that it (1) almost never paid the billed amount and (2) there is no discernable relationship between the amount of the bills and the amount Cigna paid. *See* Compl. Exs. F-X.

Cigna's claim of reliance is also implausible because it is contradicted by other allegations in its Complaint and by the exhibits attached and incorporated into the Complaint. *See U.S. Bank Nat. Ass'n*, 2012 WL 6136017, at *7. Cigna acknowledges that "Cigna-administered plans generally limit reimbursement for out-of-network services to the 'Maximum Reimbursable Charge' for 'covered services' …," Compl. ¶ 63, and that "Cigna determines what part of the member's cost is considered for coverage by the plan, …." Compl. ¶ 49. In addition, Exhibits F through X to the Complaint show that, for most of the allegedly fraudulent claims, Cigna paid only a small fraction of the costs submitted or, in many cases, nothing at all. For example, Exhibit F shows that Cigna paid nothing on a quarter of the claims submitted by Advanced Surgery Center of Bethesda and paid less than half of the billed amount on 99 of 104 claims.[8] As Cigna's own allegations and exhibits demonstrate that it independently determined the amount (if any) that it would reimburse under the applicable policies, it is not plausible that Cigna relied on the amounts submitted by the ASCs.

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[7] Cigna makes similar claims later in its Complaint, *see* Compl. ¶¶ 95, 225 & 240-241. Those paragraphs, however, offer no additional information about the particulars of Cigna's alleged reliance.

[8] Attached hereto as Exhibit 1 is a spreadsheet that takes Cigna's billing summary for ASC of Bethesda (Compl. Ex. F) and adds one additional column – the mathematical calculation of what percentage of each bill submitted by the ASC was paid by Cigna.

III. Cigna's state-law claims are preempted by ERISA.

ERISA broadly preempts state law, including the state-law claims Cigna has asserted in Counts III through VII here, for plans covered by ERISA. *See* 29 U.S.C. § 1144 (ERISA "supersede[s] any and all State laws insofar as they now or hereafter relate to any employee benefit plan …"); *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2000). As the Supreme Court has explained "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted." *Davila*, 542 U.S. at 209. Cigna's Complaint acknowledges that "the vast majority of the plans under which the ASCs have sought benefits are governed by ERISA," Compl. ¶ 47, and it has failed to identify any claims that are *not* governed by ERISA.

Cigna's state-law claims are preempted under the doctrine of conflict preemption. A claim is conflict preempted when it "relates to" or "has a connection with or reference to" an ERISA plan. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983). In this case, each of Cigna's state-law claims is explicitly connected to the applicable ERISA plans. Each count is premised on the ASCs' alleged waiver of patient co-payments, deductibles, and co-insurance required under the applicable plans and Cigna's distribution of plan funds based on allegedly false charges. Compl. ¶¶ 222, 228-229, 238-240, 244-246 & 253-254. Cigna claims that the charges were false or fraudulent because they were not the ASCs' "normal charge" for the services provided, and thus were excluded under the applicable ERISA plans. Compl. ¶¶ 61-65, 219, 238, 246 & 254. But Cigna's assertions that the payments were unwarranted and that it would be inequitable for the ASCs to retain those funds (Compl. ¶¶ 229 & 247) stem from its claim that it was not required to pay them under the terms of the plans. *E.g.*, Compl. ¶¶ 61-65 &

244. Because each of Cigna's state-law claims depends on this Court's interpretation of what was required under the ERISA plans at issue, Cigna's claims are preempted and should be dismissed.

IV. Even if Cigna's state-law claims were not preempted by ERISA, they fail for other reasons.

Even if this Court finds that Cigna's state-law claims are not subject to dismissal because they are preempted, those claims should be dismissed for many of the same reasons that Cigna's RICO claims should be dismissed.

Cigna has alleged three causes of action that hinge on the existence of some alleged misrepresentation – Count III, Fraud; Count IV, Aiding and Abetting Fraud;[9] and Count V, Negligent Misrepresentation. In each instance, Cigna claims that the ASCs misrepresented their charges for the procedures conducted or failed to disclose its pricing policy. *See* Compl. ¶¶ 221-224, 228 & 238-239. However, as explained above, the ASCs were not obligated to disclose their pricing policy, *supra* at p. 18, nor did they make any misrepresentations about the fact that their patients' cost-sharing requirements were billed at in-network rates; that information was fully disclosed on the claims forms the ASCs submitted to Cigna, *supra* at pp. 19-20.

To properly state claims for fraud and negligent misrepresentation, Cigna must also allege that it justifiably relied on the alleged misrepresentations. As discussed above at pages 21-22, Cigna has failed in this regard. Its allegations of reliance do not meet the heightened pleading standard of Rule 9. Its claim of reliance is implausible even under Rule 12(b)(6) because it is contradicted by Cigna's acknowledgement that it "determines what part of the member's cost is considered for coverage by the plan," Compl. ¶ 49, and by its Exhibits F-X, which reveal that it paid nothing on dozens of the claims submitted by the ASCs and a tiny fraction of many others. Cigna's failure to properly allege both an actionable misrepresentation and its reliance on such misrepresentation requires that its fraud and misrepresentation claims, Counts III, IV, and V, be dismissed.

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[9] The Maryland Court of Appeals has held that the sufficiency of a claim for aiding and abetting depends on whether the plaintiff has adequately alleged the underlying tort. *Alleco, Inc. v. Harry & Jeanette Weinberg Found. Inc.*, 340 Md. 176, 201 (1995).

Based entirely on Cigna's allegations of fraud, Count VI of Cigna's Complaint (for "unjust enrichment") is simply another iteration of Cigna's claim for fraud hiding behind an equitable banner. Because the fraud allegations are insufficient, so, too, is Cigna's claim for unjust enrichment. Indeed, to the extent that Cigna is seeking to avoid paying for services that its insureds received and for which it (or the plans it administers) would otherwise have to pay, it is Cigna that is being unjustly enriched. Accordingly, this Court should dismiss Count VI.

Count VII of the Complaint, Cigna's Claim for Tortious Interference with Contract, should be dismissed for similar reasons similar to those for dismissing Counts III-VI. To state a claim for tortious interference, a plaintiff must allege intentional and wrongful or unlawful conduct by the defendant that proximately caused the plaintiff's injury. *Lyon v. Campbell*, 120 Md. App. 412, 431 (1998). Here, Cigna again relies on its claim that the ASCs engaged in fraudulent behavior by submitting allegedly "inflated" charges, Compl. ¶ 254, and misrepresenting to patients that they could use their in-network benefits at the ASCs, Compl. ¶ 255. Again, as discussed above, Defendants did neither.

Count VII should also be dismissed because Cigna has not alleged that its insureds breached their contracts with Cigna – another critical element in a claim for tortious interference. *Fowler v. Printers II, Inc.*, 89 Md. App. 448, 466 (1991). The closest Cigna comes to such an allegation is its claim that the ASCs maintained a dual pricing scheme "to induce the patients to use the ASCs' out-of-network services, and to undermine and circumvent Cigna's provider network system." Compl. ¶ 254. But inducing patients to use out-of-network services does not constitute a breach of the patients' plans because, as Cigna admits, its plans expressly allow patients to seek care from an out-of-network provider. Compl. ¶ 48.

V. Because there is no valid cause of action before this Court, Cigna's claim for a declaratory judgment must be dismissed.

In Count VIII, Cigna seeks a declaration from this Court that "the claims for reimbursement submitted by the ASCs are not for covered services and are not payable under employee health and welfare benefit plans that are insured or administered by Cigna." Compl. ¶ 267. Cigna also seeks a declaration "that the ASCs must return all sums received from Cigna." *Id.* It seeks this relief pursuant to the Declaratory Judgment Act, 28 U.S.C. 2201(a).

Count VIII must be dismissed, however, because it is "well-settled that the Declaratory Judgment Act does not independently create jurisdiction." *Univ. Gardens Apartments Joint Venture v. Johnson*, 419 F. Supp. 2d 733, 742 (D. Md. 2006) (quoting *Gem Cnty. Mosquito Abatement Dist. v. E.P.A.*, 398 F. Supp. 2d 1, 12 (D.D.C. 2005) (internal quotation marks omitted). Rather, the Declaratory Judgment Act is simply a "form[] of relief, should the court otherwise have a valid cause of action before it." Because there is no valid cause of action before the Court in this case, Count VIII must be dismissed.

Conclusion

For the foregoing reasons, Defendants request that the Court dismiss Cigna's Complaint in its entirety.

Respectfully submitted,

/s/

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